Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN3658AGC	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY FAMILY HOME CARE	3235 DELNA STREET SPARKS, NV 89431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 3/25/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, One bed Category I residents and Seven beds Category II residents. The census at the time of the survey was six. Six resident files were reviewed and five employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 879 SS=D	449.2742(6)(a)(2) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the	Y 879		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 879	Continued From page 1 administration of the medication shall: (2) Indicate on the container of the medication that a change has occurred. This Regulation is not met as evidenced by: Based on record review and interview on 3/25/10, the facility failed to ensure that 1 of 6 residents received brand name medications as prescribed (Resident #5 - Bengay Cream, Joint Flex Patch, Lacrilube). Severity: 2 Scope: 1	Y 879		